King County

Department of
Community and Human Services

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FINAL PROCUREMENT PLAN
Veterans and Human Services Levy: 2.1(b)
Outreach and Engagement of Long-Term Homeless People in South King County

1. **Goal (Overarching Investment Strategy)**
   The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of ending homelessness through outreach, prevention, permanent supportive housing and employment (page 18 of SIP).

2. **Objective (Specific Investment Strategy)**
   Partner in initiatives to identify, engage and house long-term homeless populations (page 19 of SIP). This procurement plan addresses only the effort in South King County. The Seattle effort is still being planned and will be presented at a later date.

3. **Population Focus**
   This program prioritizes single adults in targeted areas of South King County who are chronically homeless. This is one of the primary target populations of the Veterans-Human Services Levy. The client population to be served characteristically have mental health and substance abuse conditions (including post traumatic stress disorder), and many are veterans of the U.S. military.

4. **Need and Population to be Served**
   As described above, this program is designed to serve long term homeless people in targeted areas of South King County. We base our definition of the South King County sub-region on school districts. South King County is defined as the areas encompassed by the following school districts: Enumclaw, Tahoma, Auburn, Federal Way, Highline, Kent, Renton Tukwila and Vashon

   We expect that the population will include both men and women, although the majority will be men. Many will have severe mental illness and substance abuse issues; most will have significant physical health problems. Many will be veterans.

   We expect to learn more about specific characteristics and needs of long term homeless people in South King County through the implementation of this expanded outreach. However, we do know the following:

- In the 2006 "One Night Count," there were 105 homeless unsheltered people counted in Kent, and 62 in Federal Way. (The One Night Count focuses on targeted geographic areas within jurisdictions, it is not meant to be comprehensive.)
- In the 2007 "One Night Count," 90 people were counted in Kent, 106 in Federal Way, and 56 in Renton (this area was counted for the first time.)
- The HOME and ARISE emergency shelters for single men operated by Catholic Community Services in Renton and Kent report that approximately 10% of their 80 clients are veterans.
- Of the 25 residents of the Housing First Pilot in South King County, 6 are veterans.
- The PATH[1] program of Sound Mental Health[2] is contracted to enroll a minimum of 125 (unduplicated) eligible persons during 2007. They expect that 250-375 people will be identified and assessed in order to meet the enrollment minimum.
- From 2003-2006, there were 54 known deaths of homeless people in South King County communities that came under the jurisdiction of the King County Medical Examiner. The most common cause of death was acute intoxication – typically combinations of various illegal and legal drugs. Of the 54 deaths, 39 took place in the cities of Kent, Auburn, Federal Way, and Renton.

5. Funds Available

For the specific investment strategy of "Partnering in initiatives to identify, engage and house long-term homeless people," the following funds are available.

Total Funds Available

	2007	Annually – 2008 through 2011
Veterans Levy	$141,000	$246,000
Human Services Levy	$329,000	$574,000
Total	**$470,000**	**$820,000**

As can be seen from the tables above, 30% of the funding for this initiative is from the Veterans' Levy and 70% is from the Human Services Levy. We propose to track veteran status of all clients served, and assign program costs proportionately. At this time, we project that approximately 30% of those served will be veterans. After the first year of program activity, we will reassess and adjust the program and/or funding as needed.

These funds are to be divided between the South King County initiative described in this procurement plan and a project to develop and manage a list of "high utilizers" in the City of Seattle. Please refer to Section 11 for more detail.

[1] PATH, "Projects for Assistance in Transition from Homelessness," is a federal funding source for community-based outreach, mental health, substance abuse, case management and other support services. The program is discussed in more detail in Section 6 of this document.

[2] Seattle Mental Health has formally changed their name to "Sound Mental Health" to reflect their countywide presence.

6. Program Description

According to the SIP, the goal of this strategy is to "build infrastructure and capacity in South King County for coordinated, effective outreach and engagement of chronically homeless persons and provide linkages to housing" (SIP, page 19). The SIP also recognizes the need and opportunity to improve coordination of existing homelessness response in South King County by working through such groups as the South King County Human Services Planners' Group and the South King County Forum on Homelessness. This Procurement Plan lays out a proposed program for increasing outreach and engagement to chronically homeless people, including veterans, in South King County. Please note that the funding of housing and housing-based supportive services for this population is being addressed through other sections of the SIP, and Procurement Plans for those areas have already been presented to the Levy's Oversight Boards.

Addition of two outreach workers

This program adds two additional outreach workers to the current PATH team in South King County. Projects for Assistance in Transition from Homelessness (PATH) is a federally funded program through the Substance Abuse and Mental Health Services Administration. PATH funds community based outreach, mental health, substance abuse, case management and other support services to address the needs of people who are homeless and have serious mental illnesses. Unlike many mental health focused programs in which funding is provided only for enrolled clients, PATH is unique in that it provides funding throughout the engagement process. This gives outreach workers the time and resources they need to build relationships with homeless people with mental illness – people who often have not been well served through traditional programs.

Currently King County Department of Community and Human Services (DCHS) contracts with Sound Mental Health for the South King County PATH team. That team has 1.6 full-time equivalent (FTE) staff persons providing outreach services in limited areas of South King County. The new workers will be integrated into the PATH team, trained in the "Relational Outreach and Engagement" model, (described below) and will receive clinical supervision from Sound Mental Health.

The addition of two outreach workers will increase the capacity of the team to reach new areas of South King County. In addition, the Veterans and Human Services Levy funds can be used somewhat more flexibly than the PATH funds, adding focus on chronically homeless people who are long time substance abusers and those who are veterans, complementing the current focus on persons with several mental illnesses. We expect many of those to be served will be dually diagnosed with both mental illness and substance abuse issues. Since a December 2005 Request for Proposal (RFP) process held by King County Mental Health Chemical Abuse and Dependency Services (MCHADS) resulted in the selection of Sound Mental Health for the PATH program, we propose expanding this service rather than initiating a new RFP.

Outreach will be conducted in a number of ways, with the primary emphasis on taking services to the locations where homeless people are found rather than expecting homeless

people to initially come through the doors of an office or agency. The locations the outreach workers will visit include but are not limited to encampments, parks, libraries, food programs, emergency shelters, and other locations that knowledgeable local contact people identify as places where homeless people are found.

We anticipate that the outreach team will receive referrals from police, parks staff, city staff, library staff, church workers, non profit agency staff or others who encounter long term homeless individuals. For example, a library staff person may notice that an individual who appears to be mentally ill and homeless is regularly spending long hours in the library. She can call the PATH team and ask that an outreach worker come to the library to make contact with the individual, and begin the engagement process.

The mobile medical van will be another vehicle for outreach: the medical service provider will provide a face to face introduction to the PATH worker who in turn begin the engagement process and make a plan to see the individual again. PATH workers will have access to flexible funds that will permit them to invite homeless individuals to have a cup of coffee and a sandwich, or provide a bus ticket or any other small incentive that will aid in the engagement process. PATH workers will also be responsible to ensure that their services are well-known in the targeted areas.

Why is outreach important? Homeless people, especially those experiencing serious disabling conditions and/or long term homelessness, often have difficulty finding or accepting the services and care they need. This may be related to fear, lack of awareness, ambivalence, loss of hope, or any other number of personal reasons. Too often, services are difficult to access because of significant barriers presented by the system itself. Outreach workers attempt to mediate and overcome these psychological, informational and systemic barriers to care. They offer an entryway to services and safety, providing a bridge between the streets and a more stable life. Craig Rennebohm of the Mental Health Chaplaincy, has developed a theoretical framework: "Relational Outreach and Engagement Model" for outreach to homeless people on the street. This theoretical framework is used by the PATH team, and emphasizes the development of a relationship between outreach worker and homeless person.

The length of time it takes for homeless people to engage in services varies greatly depending on the individual and his or her disabilities, as well as the availability of housing and other benefits. For chronically homeless people, engagement is typically a slow process because they have disabling conditions. The experience of the current PATH workers in South King County is that the length of time varies depending on how the client was first contacted. If a client is referred by another agency or by another homeless individual already engaged with PATH, they may engage on the first interaction. If a client is approached through assertive outreach, it is usually the 2nd to the 5th interaction before they are willing to engage. This could take a week to a month. The average time of engagement to enrollment in services is usually about a week. At that same time, there are situations where a client is met, not seen again for 2 to 6 months, and then seen again for possible enrollment in services.

PATH workers describe their clients as extremely reluctant to access services of any kind, including needed medical services. In many cases, they have been homeless and isolated for many years, and this isolation coupled with mental illness and/or substance abuse issues creates strong suspicion with regard to formal treatment services. Housing has proven to be a major incentive to engage long term homeless people. PATH has been the conduit for referring clients for the South County Housing First Pilot Project, whose 25 units are now close to full occupancy. Connection to housing is the ultimate goal, and as additional supportive housing units are developed through Levy and other housing finance resources, the expectation is that the housing developers would partner to accept referrals of these clients into portions of that housing.

Mobile Medical Service

The other proposed component of the expanded South King County outreach is a mobile medical van service. In a recent national review of mobile health care for homeless people, mobile medical is described as part of a continuum of outreach services: "The use of mobile clinics to reduce financial, geographic, and psychological barriers to health care for people who are homeless is distinctive yet complementary to other outreach methods, such as "street medicine" provided by walking teams." The report notes that there is general agreement that mobile programs are insufficient to meet the complex health needs of homeless people, but rather it is a strategy to improve access to care by providing "compassionate, culturally competent outreach; help with transportation to clinics and other incentives to promote engagement in a therapeutic relationship (food vouchers, hygiene kits clothing); a consistent mobile service schedule, and assistance in applying for public benefits including health insurance."[3]

Currently, the Health Care for the Homeless Network of Public Health—Seattle & King County provides shelter-based health outreach only to homeless families in South and East King County, but no health outreach yet exists for single adults.

Under the proposed mobile medical component of this outreach strategy, a health care organization in King County would rent an existing mobile medical van owned by the Metropolitan Development Council (MDC) in Tacoma, Washington. MDC operates the Health Care for the Homeless Program in Pierce County, but has extensive unused capacity with its mobile medical van and has indicated to the Seattle-King County Health Care for the Homeless Network its willingness to negotiate a "day rate" for the rental of the van and driver. This would allow us to test the concept without the complexity of purchasing and maintaining a mobile medical van. The number of days the van would operate has not yet been determined, but possibly 2-3 days per week depending on resources.

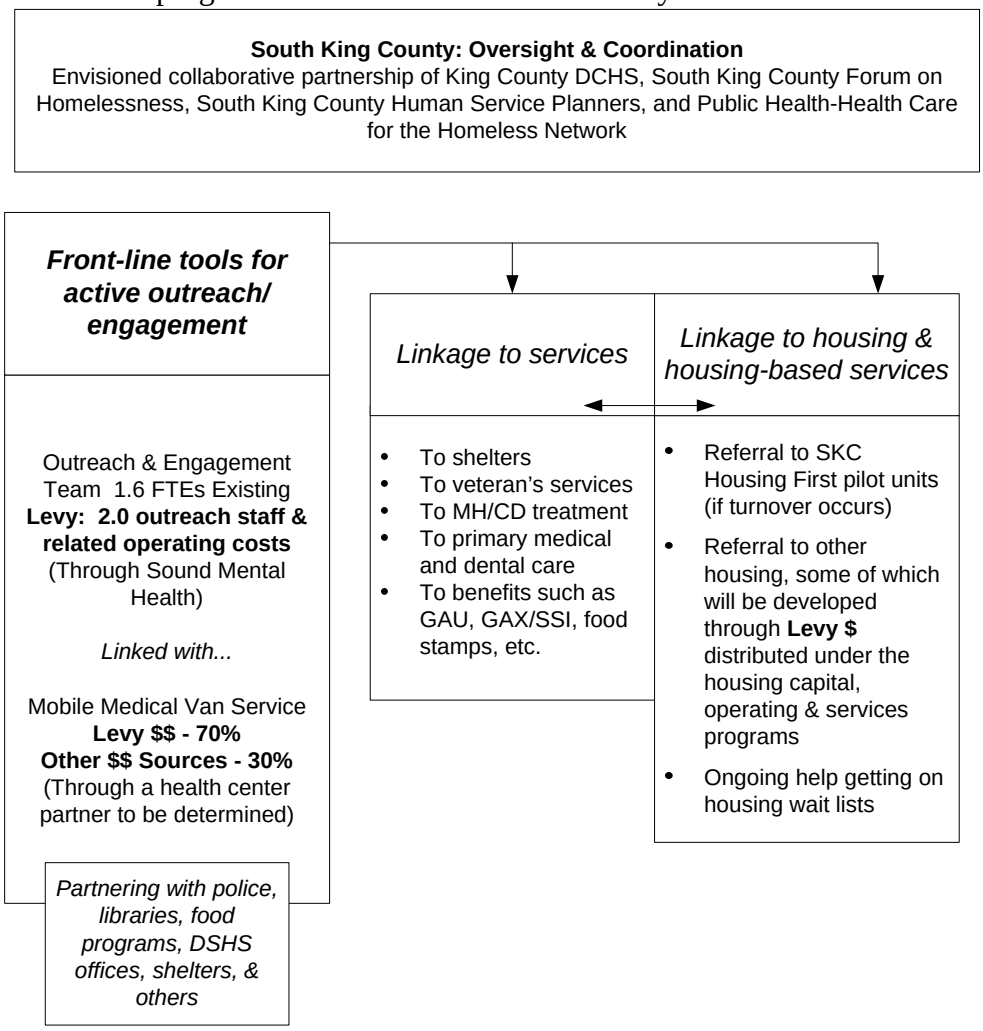
The Seattle-King County Health Care for the Homeless Network will have oversight of the mobile medical service, selecting and contracting with a qualified health center who will provide the staff and direct patient care services. Services would include health screenings, episodic care for common health conditions, STD testing, immunizations, dressing changes, and help enrolling in Medicaid if eligible. The van will be located at specific sites, on a

[3] Mobile Health Care for Homeless People: Using Vehicles to Extend Care, Patricia Post, May 2007. National Health Care for the Homeless Council.

predictable schedule, where homeless people congregate, such as free meal programs or specific parks. At least one PATH worker will be attached to the mobile medical team at all times, available to meet and slowly build a relationship with homeless individuals, ultimately helping them access benefits, needed services, and housing. The on-site medical services are envisioned as the "carrot" that begins the therapeutic engagement process. Long-time homeless people often will agree to see a doctor or nurse for a physical health issue (treatment for a cold, help with an abscess, getting a flu shot, etc.) that in turn leads, over time, to their willingness to work with other outreach staff on the underlying mental health and substance abuse problems they face.

We recognize that it is not only homeless individuals who lack medical care. Staff of the mobile medical van will be able to refer people who are not homeless and are in need of medical care, to nearby community health centers where they can obtain primary care services, regardless of whether they have health insurance. These health centers also help people with the process of enrolling in Medicaid and other public health coverage if they are eligible.

The graphic below depicts the proposed outreach effort in South King County, including ways in which the program will link individuals to other systems of care and into housing.



One of the goals of this project is to learn more about long term homeless people in South King County. How many are veterans? How long have they been homeless? Where are they and what are the best methods of engaging them? As we discover the answers to these questions, we may modify elements of this project to better meet the needs of the population we are trying to serve.

7. Coordination/Partnerships and Alignment Within and Across Systems

Planning for this project was carried out by a team of staff from the cities of Kent and Renton, South County United Way, DCHS and Public Health. Planning included consultation with other South King County Cities, non-profits and the King County Veterans Program, and, as the details of the program are developed, we will be working closely with even more partners in the target area.

The success of this project is fully dependent upon partnerships and coordination. It is designed to build on current efforts in South King County and will not "reinvent the wheel." Sound Mental Health has been sponsoring the PATH team for over a year. They have built many relationships with service and housing partners, and with homeless people. They have been the conduit for the South King County "Housing First" pilot project, which is now fully occupied. These relationships will be strengthened and expanded with the additional capacity provided through this project.

Cross-system coordination is also key to this project. Health care, housing, mental health, substance abuse, and veterans systems must work together if clients engaged through this project are to lead more secure, safe and satisfying lives. The project is clearly aligned with the goals of the ten year plan, and responds to the interests and needs of South King County jurisdictions as they craft their response to homelessness in their communities.

Additional potential partners include the police, churches, South Sound Dream Center, Multiservice Center, Community Caregiving Network and St. Francis Hospital.

Health system partners are expected to include Public Health, community-based federally qualified health centers, and Metropolitan Development Council (Pierce County), among others. Health Care for the Homeless Network researched other mobile health services operating in the region. While there are no other mobile medical programs, there is a mobile dental program operated by Medical Teams International that has partnered with selected social service agencies and churches to provide on-site dental care at a few locations in South King County. This project could explore potential future partnership with that dental program if there is a need; Medical Teams International indicated that they do have the ability to add new partner sites in King County at this time. There are also some specialty mobile screening services such as mammograms, often offered in the context of "health fair" events at particular community sites, and the Washington Dental Service Foundation operates a mobile dental program that targets low-income children. Health Care for the Homeless has existing relationships with the health organizations that sponsor such events and can assure that schedules, flyers, and program information are exchanged in order to assure maximum coordination and effective referrals.

The following table summarizes the role to be played by various partners in this effort:

Partner	Role
Sound Mental Health	Provide outreach and engagement of long term homeless people in selected areas of South King County; assist people in enrolling in services and benefits and finding housing.
Health care organization (to be selected)	Provide health services to homeless people as described above; introduce homeless people to accompanying PATH worker.
Community and grass roots organizations and other partners such as DSHS offices, police and churches.	Referrals to PATH team – y will call PATH when they know of homeless people who seem appropriate for this service; may also provide information about new locations where long term homeless people are sleeping or congregating and communicate this to the PATH team.
Metropolitan Development Council (Pierce County)	Rental and driving of mobile medical van.
South County cities (represented in the human services planners group)	Periodic consultation regarding implementation of the project
Public Health, Seattle and King County – Healthcare for the Homeless Network	Overall coordination of the medical services portion of the project, through a contract with a health care organization.
King County DCHS	Coordination of the PATH outreach portion of the project, through a contract with Sound Mental Health

8. Timeline

A contract will be negotiated with Sound Mental Health, the current PATH provider, for the two additional outreach and engagement positions. Our goal is to have a contract in place by October 1, 2007, and for the agency to complete hiring and the program to become operational during the fourth quarter of 2007.

The development of the mobile medical van service will be on a different timeline. At the point when the mobile medical service is operating, the PATH outreach workers will be linked to the van for those days and hours that it is operating. Essentially, 2007 will constitute the development and start-up phase of the mobile service, and 2008 will be the first year of the pilot.

(a) Public Health's Health Care for the Homeless Network will use a competitive process to select health center partner (August-October 2007)
(b) Negotiation with Metropolitan Development Council for mobile medical van rental; execute contracts; hire needed staff, work with community partners to select service sites, days, and hours; establish team with Sound Mental Health (October – December 2007)
(c) Secure remaining needed funding (August – December 2007)
(d) Begin mobile medical operations (January 2008)

9. Provider Selection / Contracting Process

Outreach Workers

We are proposing the addition of two additional outreach workers to the current PATH team currently operating in South King County through a contract with the King County Mental Health Chemical Abuse and Dependency Services Division (MHCADS). A Request for Proposal for the PATH Program was issued by MHCADS less than two years ago, in December 2005 for the PATH Program, and Sound Mental Health was awarded the contract. They have been operating in South King County since April 2006 and have now established productive working relationships with local resources, police and jurisdictions.

Mobile Medical Service

Public Health's Health Care for the Homeless Network will conduct a process to request letters of interest from qualified health organizations interested in managing the mobile medical service. If this process results in multiple letters of interest, a Request for Proposal process will be conducted. The selected organization would be one that can effectively link homeless people to primary medical care services in south King County, or other locations of the client's choice.

Either the selected health center partner or Public Health would rent the mobile medical van from Metropolitan Development Council: this will be determined at a later date after further exploration with MDC and the various partners regarding which approach would be most efficient and appropriate.

10. Geographic Coverage

This project will expand the range of the current PATH team to new and more rural areas of South King County. Specific locations for outreach will be negotiated in the contract, but we expect to include portions of Federal Way, Auburn, and SeaTac, and are examining the possibility of including some rural and "hard-to-reach" areas, at least on a pilot basis. Partners in South King County are working with King County staff to identify areas where long term homeless people reside. Specific sites will be identified when contract is negotiated with provider. We will plan for periodic reviews of the locations initially identified to make sure that we are reaching our target population, and will build in sufficient flexibility so that we can modify those areas if necessary.

11. Funding/Resource Leverage

The proposed budget for the South King County outreach/engagement project is detailed below.

PATH Outreach

Outreach Staff	**2007 (Oct-Dec)**	**2008**
Revenues		
Levy funds	54,000	160,000
Expenses		
Personnel & operating for 2.0 FTE outreach workers	54,000	160,000

Mobile Medical

For the mobile medical service, 2007 will be a start-up and development year, with activities focused on selecting contract partners, working with South King County cities, and working with community-based programs to develop the schedule. Part of the work in 2007 will be resource development, including applying for other funds to operate the service (at least 30% of the ongoing budget is projected to come from non-levy sources). We will also explore whether it is possible for Medicaid billing and/or Medicaid Administrative Match to take place in the mobile medical program. If so, Medicaid income becomes a planned part of the operating budget.

Mobile Medical	**2007**	**2008**
Revenues		
V-HS Levy	90,000	210,000
Other Sources TBD	0	90,000
Total	**90,000**	**$300,000**
Expenses		
Funding for year one start-up *	$90,000	N/A
Mobile medical van rental (estimated)	$0	$72,000
Mobile medical van operations		$228,000
Total	**$90,000**	**$300,000**

*Note: Year one start up activities include staff time to develop program design, raise remaining funds from public and private sector sources, run RFP process to select health care partner, work with community partners to determine sites and schedule, and negotiate for rental of mobile van. Also, we project a partial year contract with health care partner who would hire staff and likely being purchasing needed equipment & supplies.

Summary of 2007 and 2008 Proposed Use of Levy Funds (South King County Only)

	2007	**2008 -2011 (projected annual amount per year)**
Outreach expansion	54,000	160,000
Mobile Medical	90,000	210,000
Total	**144,000**	**370,000**

The remainder of the funds will be available to the Seattle portion of the outreach project, and for adjustments or expansions to the South County initiative as yearly activities and outcomes

Other Leverage / In-Kind

Training in outreach techniques and motivational interviewing for the South King County outreach and mobile medical staff will be available at no charge from Ken Kraybill, Training Specialist for the National Health Care for the Homeless Council. Ken has developed nationally-recognized curriculums in outreach to homeless people, and provides to the Seattle-King County Health Care for the Homeless Program a limited number of free trainings annually for community partners. HCH agrees to prioritize Mr. Kraybill's training for the South King County area linked to the start-up of this new project.

12. Evidence-based or best practice information

Outreach is an evidence based practice. This project would build more capacity for outreach into the current PATH team in South King County. A mobile medical van is one of the ingredients for how this outreach would be provided.

According to "Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders" outreach is "recognized as the initial, most critical step in connecting or reconnecting a person who is homeless to needed health, mental health, substance abuse, and social services and to housing. However, people who are homeless are not focused initially on receiving mental health or substance abuse treatment. Outreach workers must meet them on their own terms and on their own turf. This process of engagement is essential to develop the trust and rapport needed to help individuals accept more long-term services, the ultimate goal of outreach efforts. Regardless of how or where outreach is provided, successful outreach workers must adopt a non-threatening approach; must be flexible in the number and types of services offered, as well as the manner in which they are provided; and must make numerous contacts over extended periods of time (Interagency Council on the Homeless, 1991; McMurray-Avila, 1997).

Research shows that given the opportunity, most people with serious mental illnesses and/or co-occurring substance use disorders who are homeless are willing to accept treatment and services voluntarily. A study of individuals enrolled SAMHSA Access to Community Care and Effective Services and Supports program who were contacted through street outreach revealed that even individuals with the most severe disorders, who are the most reluctant to accept treatment, will enroll in services and show improved outcomes when served by an outreach team (Lam and Rosenheck, 1999)

A study of the effectiveness of outreach with homeless people who abuse substances found that nearly half of persons contacted through outreach became enrolled in services (Tommasello et al., 1999). More important, those contacted through outreach had significantly higher levels of substance use than walk-in clients, and were more likely to be engaged in HIV risk behaviors. This indicates that outreach can be successful in reaching individuals most in need of services.

Consist, caring, personal relationships, and the introduction of services at the client's pace are critical elements in outreach efforts designed to engage people who are homeless into treatment.

Studies of mobile medical programs have documented effectiveness, as well. In one study, a mobile medical van in New York provided primary medical care and medical referrals for homeless clients with high rates of substance abuse and HIV risk behaviors. The study sample (*N* = 250) was divided into experimental S's who received *Intensive case management* and a control group who could choose to refer themselves to the social worker. Preliminary 4month outcomes (*N*=128) showed reductions in drug use, homelessness and health complaints in both groups; experimental subjects compared with controls received more public assistance and had fewer emergency room visits.[4]

13. Disproportionality reduction strategy

In King County's homeless population, people of color are over-represented relative to their proportion in the general population. According to the One Night Count, 58% of those counted were persons of color. In the HCHN, services are organized to appropriately reach the broad population of homeless people. In 2006, 55% percent of the clients served were from racial and ethnic minority communities, confirming that HCHN is reaching a cross-section of the homeless population. HCHN addresses disproportionality by addressing racial and ethnic health care disparities in all levels of its program, from the overall model to specific best practices used in service delivery. These are described in the following section.

Sound Mental Health and the health care provider who will be selected through an RFP process will track the race of clients contacted and served enabling us to both monitor our efforts and modify our strategies as needed.

14. Dismantling Systemic / Structural Racism

It is well documented that racial and ethnic minorities receive lower-quality health care than white people. The structure of standard health systems themselves contribute to racial and ethnic disparities in health care (*Unequal Treatment*, Institute of Medicine, 2002). Therefore, the core of Health Care for the Homeless Network's dismantling racism strategy is to apply a program model that works directly to overcome the barriers inherent in the model of more traditional clinic operations by taking the services to where homeless people are located. The development and use of a mobile medical service is a challenge to the "normal" way of providing health care. In *"Racial stereotyping and medicine: the need for cultural competence* (CMAJ, June 12, 2001; 164 (12)), Jack Geiger notes that in many cases, disparities in diagnosis and treatment may not reflect conscious racial bias. "Time pressure and cognitive complexity (the need to think about many tasks at once) stimulate stereotyping…" Further, many minority patients have distrust for the health care establishment. A mobile medical model is designed to change the nature of the patient-provider interaction by having the care provider come to the patient's "turf" rather than the other way around, an approach which can remove at least some of the factors that stimulate stereotyping in a traditional clinical setting.

[4] Rosenblum et al. Medical Outreach to Homeless Substance Users in New York City: Prelimary Results. Substance Use & Misuse, v. 37, Issue 8-10, May 2002.

15. Cultural Competency

All DCHS staff will be attending a cultural competency training relating to contracts and monitoring so that we can improve our own cultural competency, as well as the cultural competency of the agencies we fund to serve an increasingly culturally diverse public. All RFP's include questions about cultural competency and how the ethnic and cultural make-up of clients served is considered in agency planning, evaluation and service provision

Sound Mental Health is committed to providing services within the cultural context of the client, be that racial/ethnic, religious, disability, and/or sexual orientation. Their staff includes ethnic minority specialists (African American, Native American, Asian-Pacific Islander and Hispanic). SMH also accesses staff and outside consultants who meet the state mental health statutes as ethnic, cultural and disability specialists if appropriate.

Public Health's Health Care for the Homeless Network is committed to implementation of the U.S. Department of Health and Human Services - Office of Minority Health's national standards for Culturally and Linguistically Appropriate Services (CLAS standards). Specific ways in which the standards have practical application in the HCH program include:

- Health Care for the Homeless advisory board is 50% people of color, including 4 individuals who are currently or formerly homeless (leadership reflects demographics of the population served).
- HCH staff—both administrative and direct service—receive regular opportunities to attend Undoing Institutional Racism trainings and cultural competency trainings.
- When conducting community assessments and program evaluations, HCH works with organizations that serve homeless people of color for support in designing and implementing culturally appropriate assessment activities. It sponsors focus groups / talking circles, provide translation and interpretation services, translate written materials into Spanish or other languages, and actively involve homeless consumer representatives in helping facilitate discussions and in analyzing assessment results.

16. Improvement in Access to Services

This is an outreach and engagement project, so its very essence is improvement in access to services. As described above, increasing the current PATH team by two additional workers will allow outreach to be carried out in several new geographic areas. Using the mobile medical unit as a vehicle for engaging long term homeless people who are averse to other formal social services will also increase access.

One of the challenges for this project will be to ensure that veterans are provided access and served competently. At this time, we do not have good data on the percentage of long term homeless people in South King County who are veterans. It is thought that a significant proportion of rural homeless people, those in remote encampments, may be veterans. The PATH team will need to continue to expand partnerships and develop strategies to reach these people.

Analysis of demographic and other data will help the project evaluate how well we are reaching long term homeless people, especially those who are also veterans, and adjust our strategies accordingly.

17. Outcomes

Expected outcomes for this project include:

- Increased housing stability
- Enrollment in treatment
- Enrollment in primary care
- Increase in income

18. Process and Outcome Evaluation

The investment strategy to partner in initiatives to identify, engage and house long term homeless populations will be evaluated on both process and outcomes by evaluators hired in the DCHS, Community Services Division. We will work with the evaluators to measure the effect of the Levy on process issues such as startup activities, contracting processes, collaboration and system level changes that occur, and on the outcomes listed above. Typical outcomes of outreach and engagement programs are increased housing stability, enrollment in treatment and primary care, increased income, including veterans' benefits and state entitlements. These outcomes are in alignment with the overall goals of the Levy.